Journal of Plastic, Reconstructive & Aesthetic Surgery (2009) **62**, 287–293

JPRAS
An International Journal of Surgical Reconstruction
www.JPRASurg.com

EDITORIAL

Genital and gender-related surgery

This is not an issue to be left on the coffee table when genteel great aunts visit. More by accident than by design, the major theme of this issue concerns reconstructive aspects of genital and gender-related conditions be they congenital, traumatic or oncological. In doing so, this issue draws attention to areas of sex and sexuality which in turn give rise to a range of emotional, political, legal, cultural and religious perspectives. In no other aspects of reconstructive surgery do surgeons tackle the reconstructive challenges with such a background of social, cultural and psychological complexity. My introduction to this complexity began on the first day of my first job as a newly appointed specialist. I was introduced to the patients by the senior registrar, Mr Barry Powell, who is now a man of great stature in the field of melanoma. Barry has always been delightfully forthright and introduced me to a patient who had been admitted with Fournier's gangrene. He had been expertly managed and debrided and my first task was to apply a skin graft to his well-prepared, denuded penile shaft. The scrotum had long since gone and the testicles were buried in his inner thighs, still attached by the spermatic cord, of course.

This was no ordinary patient though. He was a man of considerable virility and had, for the UK, an extremely large number of children from more than one mother and, by all accounts, they all lived happily in two council houses that had been knocked into one. It was not possible to dislike this man and his warm 'Earth mother' wife and with subsequent follow-up visits to review the well-healed grafts and hear of the returning sexual function, the question of further children arose. After appropriate deliberation and discussion this gentleman was admitted for scrotal reconstruction to allow his testicles to be relocated and to boost spermatogenesis. When obtaining informed consent for reconstructive procedures I do like to draw diagrams. On the evening pre-operative round I spoke with the patient and his wife about the plan to use two medial thigh flaps to create the new scrotum. It is customary when depicting the male genital area diagrammatically to represent the sloping upper inner thighs in linear form conjoined superiorly with a scrotal representation by a bottom-rounded 'W'. The penis is placed almost as an after thought with delicate sensitivity as to size and angulation. In my pre-operative diagram I drew the upper inner thighs but realised I had no scrotum to represent and so conjoined the thighs with perhaps a rather larger penile representation than was customary practice. This seemed to please both my patient and his wife because in truth, there was an element of lymphoedema in the genital region that was causing an apparent and actual increase in girth and elongation of the resting anatomy. Moving forward, the diagram disappeared, the operation was successful and the wife became pregnant. Sadly a baby boy was stillborn but they named him after me before his burial. A subsequent pregnancy occurred and a healthy baby girl was born and she was named after the female Australian registrar who was working with me at that time. I was invited to be this girl's godfather and was delighted to accept.

The story could end there but it does not. I was somewhat surprised to be sent a copy of my pre-operative diagram by a patient in north-east England. Somehow it had found its way into *The Sun* newspaper. This was one of the widely read tabloid papers that was associated with a rather more liberal attitude towards illustrating the more restricted areas of human anatomy than the broadsheets. I was rather alarmed to find my diagram illustrating a brief article which named me as a surgeon from Bristol who was responsible for reconstructing male genitalia of massive proportion. This was somewhat embarrassing professionally for me but nothing compared to what my secretary had to endure over the subsequent months, with enquiries from all manner of patients who were in various states of distress or deficiency. It was through these cries for help that I learned of the despicable practice of taking the life savings of Welsh widowers and flying then to Florida to receive autologous fat injections for penile augmentation that lasted long enough to return the disorientated and jet-lagged patient to the airport for the flight home. It is difficult to deal with an elderly man in tears as he displays a red, swollen and deformed penis, his pain compounded by his shame.

But there were some other enquires that resulted from this diagram in *The Sun*. These came from Manchester where there was an active group supporting the female-to-male (FTM) transsexuals. The major challenge here is the phalloplasty but mastectomies are also required. I received a number of what in those days were 'extra-contractual referrals' from psychiatrists with FTM patients seeking surgery. Whilst confident with the mastectomy I was not confident with the phalloplasty and so it was that I

decided to visit the most experienced and accomplished European surgeon in this field, Joris Hage. Amsterdam is a beautiful city in the Spring and it was a pleasure to visit and take in the Rembrandt exhibition in the Rijksmuseum before going to the hospital of the Free University of Amsterdam. I met Joris after his theatre list to see some patients and talk about his surgical techniques and philosophy. Joris took me into a bright and colourful ward to meet some patients. We were soon surrounded by a multinational group of extremely beautiful young women and I was not a little surprised to learn that this was the male-to-female ward. Later Joris explained to me that there were two distinct groups of patients; those that wanted to undergo a complete transformation of their physical sex with breast augmentation, castration and vaginoplasty — all of course preceded by appropriate hormonal and counselling therapy. There was another group, however, who wanted to retain the penis and scrotum: the shemales. In Europe these are not as common as in Thailand but certainly represent another fascinating expression of sexuality.

Back in the UK, I was invited to speak at a public meeting of the FTM association and so one Saturday afternoon I found myself walking up to the door of a church hall in a Regency town north of Bristol. I was led into a hall that was packed with people. There was an atmosphere of encouragement in the air — mutual encouragement amongst the crowd and I sensed a feeling of encouragement for me to relax, interact, mix and mingle. There was nothing special about this crowd; there were couples, family groups, young children and some elderly people laughing and chatting. Leather jackets, tweed jackets, jeans, boys, girls, men, women. Nothing special in terms of how they looked, how they acted: but there was something very special about them. After being given an overly generous, flattering introduction I gave my humble talk and we moved onto question and discussion. It became apparent that of the 70 to 80 people present only myself, the vicar and another visitor were born as biological males — biological in terms of anatomy and psychology. The other males were in various stages of transition; either dressing as males, on hormone treatment or at various stages of surgery. I met loving family groups where the wife was the biological mother of the children and the husband was a female-to-male transsexual who was the father for the children. I met some young men who explained that they were gay transsexuals and some who said they were bisexual but wanted to express themselves from the masculine perspective. I left the meeting with the understanding that transsexuality is perhaps the most extreme form of congenital anomaly and felt an embarrassment at the way the 'Establishment' presented obstacle upon obstacle for such patients, such people, to receive appropriate care and support. I was shocked when I met for the first time a patient who had travelled from London for a private consultation. A broad chested, thickset taxi driver with a beautiful wife and child; a warm and confident personality on the outside. He was the victim of a 'fly-by-night' plastic surgeon who had raised an abdominal tube pedicle flap which was subsequently divided leaving it anchored in the suprapubic region. Salvage surgery was needed, but to achieve this in the private or public sector was extremely difficult. I was able to identify an extremely capable and sympathetic gynaecologist who was prepared to perform the necessary hysterectomy and bilateral salpingo-oopharectomy but finding a hospital in which to perform the procedure proved impossible. Another unfortunate experience involved a public hospital request to see a lady with one hypoplastic breast; the referral was for an augmentation. The patient came to the clinic with short hair, leather jacket, jeans and was not exactly feminine in her body language or demeanour. I subtly probed her views and feelings and uncovered her desire to have the normal breast removed and to find a programme she could enter for FTM reassignment. I wrote a letter to her/his family doctor, a male, and received a blistering response accusing me of unprofessional practice and undermining his authority and care. It was astonishing, but a reminder about how closed many in the medical profession are to gender-related issues.

To conclude this personal reflection I was subsequently referred several patients from gynaecologists and general practitioners who appreciated my non-judgemental perspective and relaxed but professional attitude when discussing sexual matters. These patients were ladies who had large labia that interfered with the spontaneity of sexual intercourse requiring manual separation to allow penetration. I was delighted to deliver a surgical solution which was both functional and aesthetically pleasing. These experiences all relate to the UK which I left 10 years ago. I was alarmed to receive recently John McGregor's letter raising concern about the potential of contemporary surgeons performing such aesthetic and functional procedures being charged with genital mutilation. I have placed his letter as an Editorial and am delighted to include Mr Erik Scholten's comments as an accompanying Editorial. To complete the editorializing I have asked Joris Hage to reflect upon the changing trends in genital and transgender surgical treatment. I hope that this issue will provoke thought and stimulate discussion. The appropriate expression of an individual's sex and sexuality should be one of the core human values respected by civilised societies. Our role, as reconstructive surgeons, should be to allow that expression to occur by the appropriate management of trauma, tumour or congenital absence or loss. This issue gives rich insights into how we might develop this role and achieve our goal.

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doi:10.1016/j.bjps.2009.01.001